Palliative Care for COVID-19: Let Us be Prepared…

Sir,

Not very fortunately, we are in an unprecedented humanitarian crisis due to COVID-19 infection. Epidemiologists in India have predicted an alarming increase in the number of active cases.[1] Dismally, we are not very well equipped to accommodate the exponentially increasing SARS-CoV2 patients, and there might be a time when patients would be denied access to critical care during the process of triaging, but they will have a right to expect high-quality palliative care in place of a ventilator.[2] Failure to provide benevolent and humane care to all would be an even more tragic state. This document provides in brief the preparedness required in tertiary care hospitals in India.

To Whom?

1. Symptom management for all the patients, on advanced life support or not
2. People whom we are not able to offer life-sustaining support while triaging, e.g., elderly patients presenting

with bilateral pneumonia with severe dyspnea, patients with a known advanced illness such as cancer, patients with end-stage organ failure such as kidney, lung, or liver, patients presenting with a superimposed SARS-CoV2[3,4]

3. Specialist palliative care for patients with refractory physical symptoms, depression, grief, anxiety, and existential crisis (spiritual concerns); patients with pre-existing drug use disorder; patients who are denied access to critical care owing to a triage protocol despite wanting aggressive care; and patients with drafting advance care plans.[4]

Where?

- Emergency department (ED)
- Triage area
- Isolation wards
- Intensive care unit (ICU).

What?

1. Stuff

Symptom management kits including drugs (such as morphine, fentanyl, haloperidol, metoclopramide, midazolam, dexamethasone, hydrocortisone, and sedative drugs), subcutaneous and intravenous cannula, infusion systems (e.g., pumps or syringe drivers), general equipment for taking care of bed-bound patients, mouth swabs for dry mouth, opioid lock boxes, nasogastric tubes, urinary catheters, wound dressing, suction apparatus, portable oxygen, and personal protective equipment (PPE) for healthcare delivery personnel should be made available in the ED, isolation areas, and ICUs for all clinicians and paramedics.

2. Staff

During a surge in the number of patients as might be expected, palliative care specialist would not be able to provide care to all the dying patients, other professionals including junior residents, medical officers, staff nurses, nursing educators, pharmacists, psychologists, social workers must be roped in to adapt to various roles in symptomatic care, end of life care, communication, care of the separated family, managing grief and bereavement.

Education for all frontline health care providers such as primary care physicians, nurse practitioners, paramedics, emergency department staff and nurses in ICU regarding the use and titration of opioids for dyspnea. They should be confident in using opioids for breathlessness before development of respiratory failure.

3. Space

Identify a quiet and peaceful specialized in-patient ward to provide symptomatic care for patients dying with severe respiratory failure without advanced life support.

4. Separation preparedness

- Video calling for patients with family, with or without assistance.
- Making PPE available for family members who are allowed to visit.
- Anticipating and getting prepared for managing complex grief and bereavement by a team of psychologist or counselors.

5. Communication preparedness

Compassionate and honest communication to all will be the key to manage the panic accompanying this situation, particularly while informing poor prognosis to patients.

6. Documentation

Preparation of a standardized informed consent form for the plan of care especially end of life care, and advance care planning might prove useful while caring for massive numbers of patients.

7. Care of healthcare workers

Mental health of healthcare workers should be given priority.

Making yourself (palliative care team) available and presenting these areas of preparedness to the administrative and quality teams would give us a head start. This will be an effort to help our administrators, primary doctors from EDs and triage departments, pulmonologists, and physicians in taking care of patients affected by SARS-CoV2 who would be in the frontline taking care of the most of the patients but would also be stressed while caring of the patients where priority of care might be to make patients and their families more comfortable rather than the curing the disease.

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